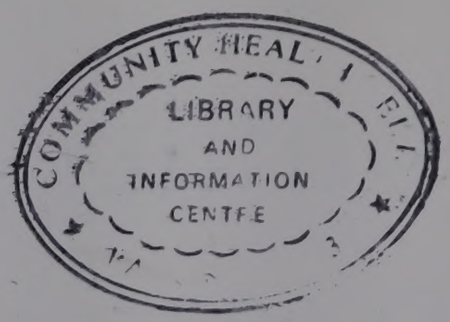
Manual on
Community Needs Assessment Approach

(formerly Target Free Approach)

in

Family Welfare Programme

Department of Family Welfare
Ministry of Health & Family Welfare
Government of India



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CPHE

FOREWORD

From first April, 1996 the Family Welfare Programme is being implemented all over India on the basis of Target Free Approach. Keeping in view the shortcomings of the target oriented approach earlier followed, the Govt. of India (Deptt. of Family Welfare) introduced the decentralised participatory planning approach from April, 1996. The abolition of centrally determined contraceptive related targets did not imply abolition of work targets for the service providers. The work and performance targets would continue to exist, but would be a summation of the felt needs of the people. The role of the Government would be to make available services, supplies and information to meet people's needs. Now the centrally determined targets will no longer be the driving force behind the programme. The demand of the community for quality services would be expected to become the driving force behind the programme making it a people's programme.

2. The changeover to a Community Needs Assessment Approach (formerly Target Free Approach) necessitates decentralised planning in consultation with the community at the grass-roots level to provide quality services under Family Welfare Programme to the community. Besides, the monitoring and evaluation of the performance also requires a fresh look at the issues of quality of care at different levels of the Primary Health Care System.

3. The Manual on Community Needs Assessment Approach in Family Welfare Programme has been prepared to provide guidance on decentralised planning at the level of SC/PHC, to improve quality of care in the services provided to the community by the Primary Health Care System of the country. This manual is a result of intense discussions in workshops participated by grass root level workers and senior officers of selected State Governments, experts of the International agencies and discussions with State Family Welfare Secretaries and Directors as well as experts in Family Welfare. Decentralised planning means close association of the community and its leading lights and opinion leaders such as village Pradhans, Mahila Swasthya Sanghs, Primary School Teachers etc. in the formulation of the PHC based family welfare and health care plan. I hope this manual will provide guidance to various functionaries at different levels of the Primary Health Care System to plan for and provide quality care to the community as per the requirements of the community under Family Welfare Programme to make it a truly people's programme.

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January 2, 1998

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1. INTRODUCTION :

Community Needs Assessment Approach (formerly Target Free Approach)

The Family Planning Programme was started in 1951 as a purely demographic initiative. Subsequently the elements of public education and extension were included to facilitate outcomes envisaged under the Family Planning Programme. During the seventies the Family Planning Programme was focused mainly on terminal methods and the programme received a set back due to rigid implementation of a target based approach. The programme has, however, remained fully voluntary and the main effort of the Government has been to provide services on the one hand and to encourage the citizens by information, education and communication, on the other hand, to use such services.

The experiences gained, within the country and outside, have amply established that the health of women in the reproductive age group and of small children (upto 5 years of age) is of crucial importance for effectively tackling the problem of growth of population. This had led to change in the approach from Family Planning to Family Welfare (FW). Since the seventh plan, implemented during 1984-89, the FW programmes have evolved with the focus on the health needs of the women in the reproductive age group and of children below the age of 5 years. Along with this, due attention has been paid to the provision of contraceptives and spacing services to the people desiring these. The main objectives of the Family Welfare Programme for the country has been to stabilise

population at a level consistent with the needs and potentials of national development.

2. The Universal Immunization Programme (UIP) started in 1985-86 aimed at reduction in mortality and morbidity among infants and younger children due to Vaccine Preventable Diseases. The Oral Rehydration Therapy (ORT) was also started in view of the fact that diarrhoea was a leading cause of deaths among children. Various other programmes under Maternal and Child Health (MCH) were also implemented during the 7th Plan. The objectives of all these programmes were convergent and aimed at improving the health of the mothers and young children by providing to them the facilities for prevention and treatment of major disease conditions. While these programmes did have a beneficial impact, the discrete and separate identity of each programme was causing problems in its effective management besides somewhat reducing the outcome. Therefore, in the nineties the Child Survival and Safe Motherhood (CSSM) Programme was drawn up and implemented from 1992-93 onwards.

3. Over the years various programmes have led to very substantial improvement in health indicators. The position with regard to some prominent health indicators for which the goals/targets were specified in the 8th Plan and in the National Health Policy (1983) are depicted in the table below :

ACHIEVEMENTS AND GOALS

Indicator	Past levels / achvt.	Current level
Infant Mortality Rate	146 (1951-1961)	72 (1996)
Crude Death Rate	25.1 (1951)	8.9. (1996)
Maternal Mortality Rate	NA	4.37 (1992-93)
Total Fertility Rate	6.1 (1951)	3.5 (1993)
Life Expectancy at Birth (years) :		
Male	37.1 (1951)	61.5 (1996)
Female	36.1 (1951)	62.1 (1996)
Crude Birth Rate	40.8 (1951)	27.4 (1996)
Effective Couple Protection Rate	10.4 (1970-71)	46.5 (1996)
Immunization status (% coverage)		
TT (for pregnant women)	40 (1985-86)	76.73 (1996)
Infant (BCG)	29 (1985-86)	93.12 (1996)
Measles	44 (1987-88)	78.91 (1996)

4. In the above context, it is important to remember that the position is not uniform all over the country. Whereas the States like Kerala, Tamil Nadu, Goa, Maharashtra and Punjab have achieved a considerably higher level, the States like U.P., M.P., Bihar, Rajasthan, J & K, Assam and Orissa are performing much below the national level. This has been a matter of great concern because these States also happen to be very populous. Unless performance in these States improves, the national performance will continue to remain depressed. The results at ground level are influenced by a number of factors like investment for the programme at National/ State Level, efficiency of the State Health System and response of the people. The deficiencies in implementation of the maternal and child health services have been responsible for a high incidence of maternal mortality and child/infant mortality and low health status of women and children. Poor prospect of health and life of the children is one of the prominent factors leading to the birth of more children per family.

5. The Approach Paper to the Ninth Plan brought out by the Planning Commission has pointed out that Governmental investment for Family Welfare during the 8th Plan has not only been lower than the outlays projected in the 8th Plan but has also been lower than the investment in the 7th Plan. This is a severe handicap particularly when it is noted that in almost all respects, the health care system needs upgradation. Above all, it needs to reach out to many

more people for the achievement of national goals. While there is a steady improvement due to economic development, spread of education/literacy and the empowerment of citizens, substantial problems remain with regard to education / literacy, particularly among the poorly performing States, especially because of non-empowerment of women.

6. The process of integration of related programmes initiated with the implementation of the CSSM Programme was taken a step further in 1994 when the International Conference on Population and Development at Cairo, proposed the unification of programmes for Reproductive and Child Health (RCH). The RCH approach seeks to underline that "People have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and child birth safely; the outcome of pregnancies is successful in terms of maternal and infant survival and well being, and couples are able to have sexual relations free of fear of pregnancy and of contracting diseases". This concept is in keeping with the evolution of an ongoing integrated approach to the nationwide programmes aimed at improving the health status of young women and children. It is obvious and logical that integrated RCH Programme should help in reducing the cost of inputs to some extent because overlapping of expenditure would no longer be necessary and integrated implementation should optimise outcomes at the field level. The 9th Plan accordingly seeks to

integrate all the related Programmes of the 8th Plan. The concept of RCH is to provide to the beneficiaries need based, client centred, demand driven, high quality integrated RCH services. The RCH Programme is a composite programme incorporating, inter alia, the inputs of the Government of India as well as funding support from external donor agencies including World Bank and the European Commission. It has been taken up in recognition of the legitimate right of the citizens to be provided with all the facilities for Reproductive and Child Health. Therefore, the RCH Programme must seek to provide relevant services for assuring reliable Reproductive and Child Health to all citizens.

7. The overall objective since the very beginning of the Family Planning Programme has been that population of the country should be stabilised at a level consistent with the sustaining capacity of national development. It is now well established that parents keep the family size small if they are assured about the health, survival and longevity of the children and there can be no greater assurance of good health, survival, and longevity of children than through the provision of health care for the mothers and the young children. Therefore, RCH Programme, by ensuring small families, also ensures the stability of population in the medium and long-term though, in the short-term, population is controlled more effectively by the use of spacing and terminal methods for avoiding unwanted pregnancies.

Therefore, the overall strategy of the Government of India (Department of Family Welfare) is to simultaneously strive for providing Reproductive and Child Health arrangements for the country's population and also to promote the use and organise the availability of contraceptive/terminal methods for the couples desiring these. It also needs to be recognised that the measures through the health system alone do not and cannot assure success in either ensuring Reproductive and Child Health or in controlling population. These objectives can be achieved by taking the following steps simultaneously :

(i) public expression of policy support by opinion leaders at different levels, in different sectors of the national system and by the community at large. Without this kind of support, people hesitate in making use of even widely available services;

(ii) provision of adequate resources for making Reproductive and Child Health services available to all the rural and urban communities in the country;

(iii) ensuring a high level of performance among the health workers and adequate efficiency of the health system ensured by an effective system of accountability. Without such efficiency, neither the quality nor even effective access of the citizens to health services can be ensured;

(iv) improving the levels of literacy among women and raising the educational status of families;

(v) striving for improvement in the economic status of families; and

(vi) setting up sensitive mechanism to facilitate inter-departmental co-ordination and monitor the functioning of collaborative programmes for improvement in the performance of the Family Welfare Programmes as well as the other programmes identified for providing reciprocal support.

8. The RCH Programme incorporates the components of the Child Survival and Safe Motherhood Programme and further includes two additional components — one relating to sexually transmitted diseases (STD) and the other relating to reproductive tract infection (RTI). The main highlights of the RCH Programme are :

(i) integration of all interventions for fertility regulation and maternal and child health with reproductive health programmes for both men and women;

(ii) reorienting the provision of services to make these client centred, demand driven, high quality and based on the needs of the community assessed through decentralised participatory planning and the target free approach;

(iii) upgradation of the level of facilities for providing various inter-

ventions with due care to quality. The First Referral Units (FRUs) being set up at sub-district level will hereafter provide comprehensive emergency obstetric and new born care. Similarly RCH facilities in PHCs will be substantially upgraded;

(iv) all-round improvement in the access of the community to various services which are commonly required by it. It is proposed to provide facilities for MTP at the PHCs counselling and IUD insertion at the sub-centres, in a phased manner;

(v) provision of greater access to out reach services, particularly for the vulnerable groups of the population who have, till now, been left out of the planning process. For this : special programmes will be taken up for urban slum-dwellers, the tribal population and the adolescents;

NGOs and Voluntary Organisations will be involved in a much larger way to improve the out-reach and make it a people's programme;

practitioners of ISM will be trained and research & development in ISM will be supported to improve the range of RCH services; and

Panchayati Raj System will be assisted to play greater role in planning, implementation and assessment of client satisfaction.

9. Hitherto, the achievements of Family Welfare Programme were assessed on the basis of the targets given from above for individual contraceptives. This led to a situation where the achievement of contraceptive targets had become ends in themselves. The top down target approach was started with the supposition that the achievement of contraceptive targets somewhat would definitely lead to a decrease in birth rate and subsequently in decrease in population. However, over the years, it became apparent that there were numerous drawbacks in the top down target approach. In the top down target approach the higher authorities decide as to determination of what kind and quantity of contraceptives need to be canvassed. Thus, the user preference is not reflected in the targets. If the contraceptives required in accordance with the needs of the users are not available, the targets are not likely to be realised. As of now, there is no authentic system of feed back regarding what contraceptives need to be promoted in a particular area among a particular age group. Another drawback of the top down target approach is that in this approach the quality of service becomes secondary and does not receive due attention. If the targets for sterilization were to be achieved but the complications were at a high rate because the quality of service was compromised while selecting and dealing with cases for sterilization, the net result would be negative. Similarly in the case of IUD, if the discontinuation rate is very high because in the attempt to fulfil targets for the number of IUD insertions, the

quality of care is compromised, specially while screening women for pre-existing RTI and STI before IUD insertion, the acceptability of the IUD programme would receive a serious set back.

A third disadvantage that has been observed with the top down target approach is that people may be tempted to resort to false reporting to claim laurels for having fulfilled the targets. If this passes muster from year to year, it would have a very adverse impact on the work culture of the field functionaries.

According to the National Family Health Survey conducted in 1992-93, the percentage of contraceptive acceptance was less than those indicated by the statistics provided by the districts and State Governments. It was also noted that the state which had reported a high acceptance rate for sterilization had not achieved corresponding reduction in the birth rate. A telling illustration of the true picture in regard to performance under the targets set in the top down approach becomes clear from the fact that a disproportionately large portion of the target (upto 40%) is achieved in the last three months of the financial year instead of the services being provided evenly throughout the year.

Since the past few years, the government of India has come to the conclusion that contraceptive targets and cash incentives have resulted in the inflation of performance statistics and progressive deterioration in the quality of services. Therefore, the Government of India held con-

sultations with all the State Governments and deliberated objectively on the utility of retaining the practice of directly or indirectly determined the targets at the national and state levels.

One district in each of 18 states, including pilot projects in Kerala and Tamil Nadu, were made target free in the year 1995-96. Subsequently, in April 1996, the department of Family Welfare of the Ministry of Health and Family Welfare, Government of India adopted the target free approach all over the country to improve the quality of services. This bold and unprecedented step was taken in spite of the likelihood that the level of achievements reported for the current and a few later years might fall below the level of performance reported for earlier years.

The practice of fixing targets from above has been stopped in the light of this background, since it was proving counterproductive.

It needs to be understood at the outset that target free approach does not mean the licence to do no work. Actually population goals remain the same as before and after targets from above are withdrawn the health workers are expected to consult families and local communities in the beginning of every year in order to assess their needs and preferences and then work out for themselves the programme and requirement for the coming year. The requirement for each village needs to be worked out to arrive at the requirements for the ANM; this becomes the targets for ANM for the year. The work load of the different ANM's

under one PHC, when added up, would determine the work load or requirement for that PHC. Similarly requirement at district level would be worked out by adding up the requirement at all the PHCs.

The mechanism for quantifying work load and the unthinking rigidities associated till now with the targets have undergone a change. The arbitrariness of the top down targets is being given up to allow the choices of the citizens to be ascertained and fulfilled. Therefore, progress under the participatory system should be faster than before. After withdrawal of the top down target approach, the test of an ANM, PHC or a district working well is that the pace of progress gets accelerated because the activities undertaken correspond with the real requirements of the people. It may be recalled that the TFA manual of 1996 laid down that the health worker would assess the community's felt needs and then set the performance norms for herself through a consultative mechanism.

After the implementation of the target free approach on the lines of the manual for programme planning and the assessment of performance at the district level through the achievements of the Sub-centres and PHCs for almost 18 months, it was found that the health worker was handicapped in fully utilizing the manual and setting the performance norms for herself due to complex calculations required for filling a large number of forms. Therefore, two workshops were held on August 19 and August 28 in the National Institute of Health & Family Welfare in

which grass-roots level workers like ANMs and MO of PHCs of different states, state and district level health administrators and ministry officials were invited to give feedback on their experiences of the target free approach as well as the effectiveness of the manual.

As a result of the deliberations in these workshops, the following problems were identified :

(1) Monthly reports were not coming from ANMs and MOs of PHCs. Therefore, in due course, monthly reports from the districts were also discontinued. The reasons given were that there were too many forms requiring too much information which the ANMs and MOs of PHC found difficult to handle and provide.

(2) Although the objective was that the requirement should be worked out in consultation of the community, the forms did not reflect the consultation process but were based instead on standardized calculations. Therefore, these formats did not fulfil the objective of activating a consultative mechanism.

(3) The forms and manual tended to lose focus because of the inclusion of a number of things which were not essential to the processes of planning and assessment according to target free approach. The manual has since been revised with the following objectives :

(a) the operation of consultative mechanisms should be reflected in the strategy for the evolution of working arrangements; and

(b) the reporting system and items to the reported should be as few as possible to avoid burdening the ANMs and MOs of the PHCs and thereby facilitate regular submission.

In the meeting of the State Secretaries held in September, 1997, it was decided to rename the target free manual, after the necessary modification, as the

2. Community Needs Assessment Approach Manual

RCH services to be provided at the sub-centre, PHC, CHC/FRUs are :

I - Maternal Health

(A) Antenatal Care

- Registration of pregnancies.
- Providing essential antenatal care (at least 3 visits)
- Iron prophylaxis to pregnant and lactating mothers.
- Detection and treatment of anaemic mothers.
- Management/referral of high risk pregnant mothers.

(B) Natal Care

- Increasing proportion of deliveries by midwifery trained personnel.

- Increasing proportion of institutional deliveries.

(C) Post-Natal Care

- Provision of at least 3 post-natal visits.
- Monitoring and care of the new born.
- Referral/management of high risk new born.

(D) Provision of care for Unwanted Pregnancies

- Referral/management of unwanted pregnancies through MTP's and safe abortion.

(E) Identification and Management of RTI/STI

II - Child Health

- Immunization of children against Tuberculosis, Diphtheria, Pertusis, Tetanus, Polio and Measles.
- Prophylaxis for prevention of anaemia and Vitamin A deficiency.
- Management of acute respiratory diseases (Pneumonia).
- Management of acute diarrhoeal diseases with ORT.

III -Contraceptive Services

- Sterilization
- IUD
- Oral Pills
- Condoms

IV - Recording of Morbidity and Mortality

- Incidence of vaccine preventable diseases and cases of ARI and acute diarrhoea
- Incidence of RTI/STI

- Number of maternal deaths and child deaths

V. A.N.M.

In the context of the Family Welfare Programme, ANM is the key person on whom the outcome of the programme depends. It is of vital importance that the ANM appreciates the importance of her contribution.

To be a good ANM, it is necessary that

(i) she should be a qualified person recruited after the requisite training. She should regularly participate in inservice training for upgradation of her knowledge and skills;

(ii) she should be a good motivator and counsellor;

(iii) she should motivate and counsel adolescents in the area about reproductive health so that they are not misinformed : they have to be treated as youth on the threshold of adulthood;

(iv) she should motivate the coummunity for delayed marriage explaining that before a particular age the human body is not ready for the stress of child bearing;

(v) she should motivate recently married couples to use temporary methods of contraception;

(vi) she should motivate women with 2 or more children to use terminal methods of contraception;

(vii) she should motivate women of the community to avail of the facilities for antenatal care during pregnancy;

(viii) she must educate them that 15 out of every 100 pregnant women are likely to have problems during pregnancy. Therefore, it is important for all women to have preventive antenatal care which helps in the detection of possible complications;

(ix) she must learn how to use the haemoglobimeter to facilitate detection and treatment of anaemic mothers;

(x) she must counsel all pregnant women to have two doses of Tetanus Toxoid, prophylactic dose of IFA tablets, balanced diet and adequate rest;

(xi) she should encourage women to have domicialiary deliveries by trained personnel or institutional deliveries;

(xii) she must educate women about the danger signs during pregnancy and delivery;

(xiii) she must motivate women to come for post-natal check ups;

(xiv) she must motivate women to bring their children for immuni-

zation;

(xv) she must motivate women to bring their children for administration of Vitamin A solution every six months starting from nine months of age till the age of three years;

(xvi) she must counsel women to bring children with breathing difficulties for examination and treatment to the sub-centre;

(xvii) she must educate women about the process and role of oral rehydration therapy with ORS or home available fluids and urge them to bring the children for examination and treatment to the sub-centre;

The ANM would be able to discharge all the duties listed above if she has close rapport with the community. To ensure this there are certain routines which, if practiced, would enable her to have a close rapport with the community.

(a) She should have fixed days of the week in office so that people will know that she will be available there positively on those days.

(b) She should have fixed days of the week, when she would go to villages, as far as possible, according to a fixed roster.

(c) During her village visits, she should visit the anganwadis so that

she would meet the women and girls. This will enable her to listen to their views on health care and contraception and also enable her to motivate and counsel the community about health care and contraception. She should involve the anganwadi workers in this effort. She should also hold meetings with the Mahila Swasthya Sangh and listen to their views about health care and contraception and use these meetings as forums to motivate and counsel the women on appropriate health care and contraception. She should visit as many families as possible in the village and motivate people to avail of the facilities of health care that she can provide. She must motivate people to have small families and give appropriate advice in this context.

(d) She would be creating a lot of goodwill if she could visit schools and undertake health-checks to ensure that children have had full immunization and are referred for check-ups at PHCs by the medical officer if they suspect any health problems. She should also assist the school teacher in health education to the extent possible.

(e) It is very necessary that the ANM checks up her stocks of medicines etc. on a regular basis so that she can obtain replenishments before the stocks are exhausted. She must besides performing the tasks assigned to her also interact with the medical officer, and lady health visitor to report the work

done by her, to replenish stock of supplies and clarify any doubts if necessary.

VI. Male Health Worker

Although, the male health worker is primarily involved with the national programmes of Malaria, Tuberculosis and Leprosy, he is also supposed to work for family welfare programme.

(a) During the trips to the village -

- He should meet members of the Panchayats to establish rapport with the opinion leaders of the village and motivate the men folk to ensure greater male participation in the family welfare programme.

- He should motivate the men for sterilization and the use of condoms.

- He should educate men about RTI/STI and motivate the men with problems to seek medical attention and assist them by referring them to the medical officer of PHC.

- He should assist the school teachers in health education to the extent possible, especially in dealing with adolescent boys.

(b) When he is at the sub-centre he should invariably attend the

office of the Sub-centre and assist ANM in the following activities:

- Immunization
- Dispensation of ORS packets
- Detection and treatment of ARI
- Motivation of male sterilization
- Condom distribution

VII. Preparation of the Sub-centre Action Plan

Sub-centre action plan is the first step in the process of decentralized planning. It provides a basis for determining the service requirement of the population of the area. The first step in the process would be to work out the requirement by conducting a household survey to compile relevant information required as per the format prescribed for Sub-centre Action Plan. The household survey should be conducted in the months of February and March. However, considering the fact that the data obtained through such surveys may have a large margin of error, the above mentioned estimate of requirements would need to be validated through discussions with the anganwadi workers, Mahila Swasthya Sangh and Panchayat health committee members. Besides these, a comparison with impersonal information relating to the birth rate of the area and the achievements under various items in the previous years would ensure that the estimate of requirements would be as realistic as possible.

How to conduct the Consultative Process ?

The ANM must have discussions with the anganwadi worker, TBA,

members of the Mahila Swasthya Sangh and local panchayat members etc. to estimate the felt need for the different services she provides to the local community.

- While formulating the Sub-centre Action Plan, the above mentioned people should be consulted and the advice given by them should be taken seriously into account. This would, besides providing useful inputs, also give the people concerned a sense of participation and motivate them to help in the implementation of the action plan of the Sub-centre.

The ANM, while making a visit to the households she serves, can also ascertain the details of the overall health care requirements of the community.

By way of preparatory action, it would be useful if the ANM develops a list of questions with which she could initiate inter-action.

Once the needs or the requirements are assessed by the consultative process the data derived would have to be compared with the figures of earlier years as well as the estimates of pregnancies based on demographic trends for the area. This would enable the ANM as well as the planners at the district level to appraise the validity of the requirements assessed. In this connection, it has been decided that

(i) the requirements/needs should be compared to the figure of

actual achievements in the previous years (and not the targets). In the subsequent years also, for determing requirement, the previous years' achievements could be used as a yardstick. However, for preparing the estimates for 1997-98, the figures of 1996-97 may not be used (figures for 1995-96 should be used) since these were compiled under entirely different premises.

If the quality of work is good and the requirement has been assessed with due care, the requirement for the coming year would be 5 - 25% higher than the achievement in previous year.

If the requirement assessed for the coming year is not even 5% higher than the achievement of the previous year, then the ANM's figures would require careful checking up to discourage deliberate under-estimation of the requirement. If the requirement assessed is more than 25% of previous achievements, then too it would require careful reassessment because these too may reflect an unrealistic assessment of the requirement for the coming year.

(ii) The requirement worked out through a survey should also be compared with the estimates emerging from demographic calculations.

To estimate the probable number of pregnancies that may occur in any area, the following formula could be used.

Probable number of pregnancies = Population of the area x Birth rate of the area (district/state)

Once the probable number of pregnancies are estimated this also will be the probable number of deliveries that an ANM can expect in her area.

The number of antenatal registrations to be expected would be the probable number of pregnancies with an additional 10% of that number to account for abortions.

According to the number of antenatal registrations the MCH services e.g. ANC visits, TT doses, IFA administration can be estimated.

It has been observed that 15% of the antenatal women registered in a population are usually high-risk. Thus to estimate the number of high-risk women that an ANM can expect she should compare her figures with a number which is 15% of the expected antenatal registration.

It has also been observed that 50% of the antenatal cases registered are anaemic. Thus the ANM should compare her figures with a number which is 50% of the expected antenatal registration.

The number of live births to be expected or deliveries to be

expected are estimated by the following formula.

No. of live births = Population of area x Birth rate of area

It is noted that out of the total number of live births there are usually 10% of these which are sick or high-risk and need referral. The ANM should compare her figures of high-risk newborns with a number which is 10% of the number of live births.

To estimate the number of infants to be immunised in the coming year, it is necessary to estimate the number of infants alive at one year.

Infants alive at one year :—

No. of live births – no. of infants who have died during the year (No of infants who have died during the year can be calculated by using the Infant Mortality Rate of the area).

Children below 3 years of age :— can be estimated from the fact that the population of children below 3 years is 8% of total population. This figure will assist the ANM in estimating no. of vitamin A doses necessary.

Children below 5 years of age :— This age group constitutes 13% of total population. The estimation of this number would assist the ANM in estimating the number of D.T. doses to be used.

It is important to understand that neither the requirements assessed on the basis of household survey nor the figures arrived at by the demographic calculations should be treated as final or beyond question. Actually, it would be highly desirable to study past trends, talk to local functionaries of various departments such as Anganwadi workers, practitioners of Indian System of Medicine, Mahila Swasthya Sangh.

VIII. PHC Plan

General Guidelines

The PHC plan would be a compilation of all the Sub-centre Action Plans from all the Sub-centres under that particular PHC. Medical Officer incharge of PHC has to calculate the materials, vaccines, medicines etc. required to accomplish the services. Depending on the existing stock of supplies, the net requirement for serving the felt needs of the population can be worked out.

Only the additional information that is not being generated at the Sub-centre would be added on e.g. number of MTP's done, number of cases of RTI/STI treated and referred. All the information that is additional to that generated at the subcentre has been printed in capital letters on the form 2.

Attention needs to be paid to family planning services particularly to male sterilization since it is only 3% of the total number of sterilization operations.

3. Progress Reporting & Monitoring

A number of forms are prescribed in this manual (annexures) in which the reports must be made by the ANM for the Sub-centre, by the incharge Doctor for the PHC, by the incharge Doctor for the FRU/ Sub-district hospital, by the incharge Medical Officers for the District Hospital to the District Family Welfare Officer and by the District Family Welfare Officer to the State Government and the Government of India (Department of Family Welfare). Compared to the forms included earlier in the Target Free Aproach manual the forms in this manual (Community Needs Assessment Approach Manual) are fewer and most forms are simpler also. This has been done to ensure that information which is of not much use by the superior levels, need not be submitted to the superior levels. This will make the task of the reporting levels easier and therefore, it should enable them to submit these reports exactly in time.

The forms included in annexure are of 2 types, Form I is the Action Plan which has to be prepared once in every year in the beginning of the financial year by the ANM. This is the form for assessing the need of the community for her and in other word it sets down targets for the ANMs for her work during the year. Similarly Form II is the Action Plan for the PHC. Form III is the Action Plan for FRUs/Sub-district Hospitals and District Hospitals and Form IV is the Action Plan for the District. The Action Plan by the ANM must be completed for her area by the end of March for the coming year and the Action Plan in the

District must be compiled by the end of April and sent separately, one copy to the Director, Family Welfare in the State Government and another copy to the Department of Family Welfare, Government of India, New Delhi.- The Action Plan of the District may be transmitted to the State and National levels through NICNET as indicated in the relevant forms.

Form Nos. 6 to 9 are the monthly reports to be submitted by the end of the first week of the succeeding month by the ANM, PHC, FRU/ Sub-district Hospital/District Hospitals to the District Family Welfare Officer and by the District Family Welfate Officer to the State Government and to Government of India by 25th of the succeeding month. Monthly reports from the District may be transmitted to the State Govt. and Govt. of India throught NICNET as indicated in the relevant forms.

Some of the important things to remember while filling up of these forms are explained below :

I. Form 1 (Sub-centre Action Plan)

1. There are certain items of general information at the beginning of the form. Information in regard to these items will be available with the ANM however in regard to the population of the Sub-centres and birth rate (for the District/State) the information is contained in the 1991 census reports for the State/District. The ANM will have to obtain these figures in regard to population and birth rate from the census books which will be available with the District Family Welfare Officer or in the District Collectorate or with the District

Statistical Officer.

The information about population and birth rate is important because the birth rate will indicate the number of births which can be normally expected to take place in each of the villages in the ANM's jurisdiction. This would also be the number of pregnant women in the villages and comparing these figures with the number of pregnant women registered with the ANM would indicate whether the ANM is registering all the cases or she is missing many of them. The number of expected births would also indicate whether the number of vaccinations being made by the ANM and others is taking care of all the children or many children are getting missed. Therefore, the figures for population and birth rate would help the ANM and superior officers to make a reliable judgement about the reasonableness of the actual figures reflected in different items subsequently in the form.

2. In the previous month the needs under each of the items i.e., for antenatal or prenatal care, for deliveries, for vaccinations etc. was being assessed on the basis of calculations indicated in the form. This was not right because after giving up a target, the needs have to be assessed for each items through a consultative process with the local community. Therefore, in the form now prescribed in this manual the method of assessing needs by calculations only has been given up and consultative process has been defined and provided for. The assessment of needs should be made after as extensive

consultation as possible indicated in the form.

3. In regard to other services to be provided by the ANM like antenatal, natal care, etc., the form envisages figures relating to performance in the previous year and the assessed requirement for the current/coming year. This is to enable a comparison to be made with the performance of the previous year. This comparison will show whether the assessment made is realistic or not. Normally there should be increase in coverage for each item by more than 5% every year becasue of the normal increase in population and due to increase in facilities to be provided to the citizens. If the increase compared to the previous year is less than 5% it should indicate to the ANM and the superior officers that the assessment is probably incomplete or under-estimated. However, if the increase over the performance of last year is more than 25%, it should alert ANM and the superior officers that perhaps the assessment of the needs that has been made has been unrealistic. Care should be exercised in both such eventualities.

4. The form contains items relating to cases of complicated pregnancies, complicated deliveries, complications after deliveries and cases of sick new borns referred to PHC/FRU. For example it is known that about 15% of the deliveries are complicated and/unless they are handed in the PHC/FRU there can be danger to the life of the mothers. The number of referrals made to the PHC/FRU for all these categories will be an indication of how meticulously the ANM

is getting in touch with the families in her jurisdiction and how meticulously she is doing her job.

5. There is also an item relating to Reproductive Tract Infection/ Sexually Transmitted Infections in the form. RTI/STI have been included in the Reproductive and Child Health Programme for the first time now. It has been observed in assessments made by experts that about 20-50% of men and women suffer from RTI/STI. The ANMs and Male Multipurpose Health Workers should be alert to this and when they come to know of such cases they should be referred for treatment to PHC/FRU/District Hospital.

6. In regard to Oral Rehydration the performance data relating to the whole country indicates that Oral Rehydration provided to affected children is still only about 50% cases. Since the dehydration results from Diarrhoea which is the cause of death of thousands of children in the country still, this item needs special attention. If the work regarding ORT is attended to properly, the increase in work during the year should be practically always more than 15-20% compared to previous year.

7. In Family Planning special attention needs to be given to persuade men to use spacing methods if they have less than two children or sterilisation if they already have two children. Among women spacing methods must be advocated to those women who have less than two children and sterilisation to those who already have 2

children. Therefore, in the consultation and motivation process the priority group for the ANM should be girls about to be married, women who are recently married and women who have just delivered second child.

8. The suitability of estimates assessed by ANM should be discussed with the LHV/MO. These estimates are to be finalised after the LHV/MO is satisfied keeping in view the total area requirement/post performance and local situation.

II. Form 2 (PHC Action Plan)

The PHC action plan is essentially in two portions. One part is in regard to those items for which services are provided in the PHC directly like the delivery conducted in the PHC, Medical Termination of Pregnancy cases done in PHC, treatment given in the RTI/STI cases, immunization done in the PHC etc. and the other part is in regard to the services provided by the ANM. In regard to the second part the PHC has to compile the need assessment worked out by individual ANMs and fill up in the PHC Action Plan.

III. Form 3 (FRU Action Plan)

The hospitals provide generally mother and child care facilities in some cases directly like immunization etc. and in addition they provide specialist services in regard obstetric care, treatment for RTI/ STI, performing sterilisation operations etc. Therefore, these hospitals

must reflect in their Action Plan only the services they provide directly as Hospitals and submit their Action Plan to the District and Family Welfare Officer.

IV Form 4 and Form 5 (District & State Action Plan)

The Action Plan for the District must be the compilation of Action Plans submitted by all PHCs, all FRUs, all Sub-district Hospitals and District Hospitals. This Action Plan denotes the targets for the coming year for individual activities/services to be provided at each delivery point.

The Action plan for the State must be the compilation of action plan submitted by all districts.

V. Form 6 to 8 (Monthly report for Sub-Centre/PHC/FRU/Urban Health Post and others)

A monthly report envisages performance data in three different parts. First part reflected in the last column of the Form whether demand assessed for the year in the assessment made at the beginning of the year must be entered. This would allow ANM and the superior officers to see what is the progress for the reporting month in comparison with the expected achievements for the year as a whole. The second part is in the form of first two reporting columns in which the performance in the month for which the report is being submitted is compared in the current year with the per-

formance achieved in the previous year in the same month. There is seasonality in many of the events and services provided by the ANM. Therefore, while there will be natural variation from month to month in the current year, comparison with performance in the same month in the previous year would reliably indicate whether the work achieved in the month under the report has been adequate. The third part is in the form of next two reporting columns in which the performance for the portion of the year completed is compared for the current year with the performance achieved in the same portion of the year in the previous year. This comparison would also tell the ANM and the superior officers whether the progress of work during the year is satisfactory. Both these comparisons are also intended to curb the practice of showing low performance in the first 9-10 months of the year and showing high performance in the last 2-3 months of the year. Such reports of performance at the end of the year should alert the superior officers that the reason behind these could be false reporting because the normal month-to-month variation cannot allow only low performance during April-January and high performance during February-March.

When the reports for PHCs and high level hospitals are received and the report for the District is compiled the District Family Welfare Officer must carefully examine them for the following :

1. If the performance reports in the initial months of the year are very low and are high for the last few months of the year,

possibility of lethargy in performance should be suspected and the higher figures at the end of the year should alert the District Family Welfare Officer the possibility of false reporting.

2. The stock of drugs and vaccines must be watched at different levels. Normally there should be stock for 1-2 months at all levels i.e., at sub-centre level in PHC, in FRU etc. Larger than this stock is indicative of either over indenting or of non-utilisation as a result of non-performance. Action to procure additional drugs/vaccines should be taken well in time and the situation of stock being fully exhausted at any level must be avoided.

3. The work condition of key equipment in PHCs and FRUs must be noted continously to ensure that the machines that go out of order are repaired in as short time as possible. If machines remain out of order for a long period, the related services will not become available to the citizens.

4. The use of stock of vaccines and drugs reported by ANMs and hospitals must be tallied with the quantities required for the cases reported to have been covered/treated. While nominal excess utilisation of stocks is natural because there will be some wastage in all normal situations, the quantities used should not be patently excessive compared to the quantities required for the cases reported to have been covered/treated.

5. In PHCs, FRUs, Sub-district Hospitals and District Hospitals where Operation Theatres have been constructed in the past, the figures relating to utilisation of this facility in terms of IUD insertions made and sterilisation operations made must be watched on monthly basis. It must be ensured that adequate number of such cases are handled in all the places where Operation Theatre facilities have been created.

6. At the end of each monthly Form a limited space has been provided for the reporting level to mention prominent handicap/ difficulty or prominent achievement in the form of a brief narrative. This has been done because in addition to the reported data there are some material factors which could not be reflected in the data and therefore these need to be stated in a narrative form. The District Family Welfare Officer must go through these narrative in every month's report to understand the difficulties and to appreciate the achievements made at the concerned level. Where necessary action to remove difficulties must be taken promptly.

VI. Form 9 (Monthly Report from District to State/Centre)

This form is for consolidated monthly report from District to State/Centre to be submitted by 25th of the following month to State Family Welfare Department and Department of Family Welfare, MOHFW, GOI, New Delhi through NICNET.

4. Evaluation

Evaluation, by definition involves not only the compilation of the performance data but also attempts to assess the functioning of the programme and the individual personnel involved in it from the qualitiative point of view. A good evaluation report, therefore, goes much beyond an inspection report, it is based on a degree of rapport which the evaluator establishes with the programme functionaries to see the programme from the viewpoint of a participant. This helps in highlighting not only what is happening or not happening but also why things have turned out the way they have. It is proposed to undertake the evaluation of the family welfare programme by the following mechanisms.

I District Surveys

Decennial census ascertains the status of many of the RCH/ population indicators once in a decade. National Family Health Survey which was conducted for the first time in 1992-93 and will be conducted once in five years, also provides information regarding many of the RCH and population indicators. Sample Registration Survey (SRS) gives information of some of the indicators at state level only. If there is assessment at the district level, it will provide information about the effectiveness and progress of implementation of RCH programme. Such assessment will allow the State and Central Government to make modifications in the programmes and strategies

from year to year and it will also strengthen accountability of performance of the district set up vis-a-vis the clients. Therefore, it is proposed to undertake district level surveys through non-government agencies appointed by the government on an annual basis. The survey is to be started in January 1998 with 1997 as a reference year and will, therefore, also provide base line data for RCH Programme. A list of indicators has been developed in consultation with demographers, other experts and World Bank. This list contains process indicators as well as service indicators and are ascertainable through household survey.

For this purpose District level household survey will be conducted on a continued basis. Fifty per cent of the districts in the country would be covered in each year for objective assessment of performance at District level, State level and National level. On an average one thousand households per district would be surveyed covering both rural and urban areas. In urban areas special emphasis will be given to cover urban slums area. The survey would cover beside other things the following aspects :

(a) Prenatal/natal/postnatal services to women

(b) Issues relating to Pregnancy of women

(c) Family Planning issues

(d) Unmet needs

(e) Maternal mortality and issues relating to it

(f) Infant mortality and issues relating to it

(g) Knowledge of AIDS/HIV

(h) Utilisation of Public Health Services

(i) Services requirement for community

Keeping in view the seasonality and the effect of monsoon on field survey, these district level surveys will be conducted every year, in the proceeding calendar year. The field work will be done during January, February and possibly in March also.

II. Concurrent Evaluation

For the success of such an extensive and multi-level programme, it is essential to ascertain on concurrent basis whether the facilities created at various levels are functioning well and also whether the users are being extended services effectively. It is proposed to set up an independent system of concurrent evaluation to supplement the reporting system based on information provided by Government channels. The reporting system relies on the very functionaries performing various functions at various levels : therefore, it has its own limitations about reporting any weaknesses in the operation of the system.

It is now being envisaged that there will be a nodal agency at the national level to undertake concurrent evaluation and submitting monthly reports based on it to the Department. Since such evaluation will be made every month in all the 32 States/UTs, it will be a

very large task.

For the purpose of concurrent evaluation a small number of key indicators will be used to assess whether the facilities provided are operational and also whether services are being extended to users in a user-friendly manner. These items would be :

District Hospitals :

(a) Whether there is a district RTI/STI clinic with a lady doctor and a male doctor working exclusively for the clinic. How many male and female cases of RTI/STI were seen/treated during the last one month.

(b) Whether the Operation Theatre is well maintained and well equipped with the required equipment . Whether the Surgeons and staff nurses are functioning exclusively for the work of these clinics.

(c) The number of male and female sterlizations performed during the last one month and three months.

(d) Stock of Vaccines and the record of breakdown of the cold chain equipment during the last one month.

Sub-District Hospitals (including FRUs)

(a) Number of specialists sanctioned and in position.

(b) Whether the Operation Theatre is well maintained and well equipped in terms of equipments and availability of surgeons and staff nurses.

(c) The number of male and female sterilizations performed during last one and three months.

(d) How many cases of emergency obstetric care were handled in the hospital during last one month and out of these how many were referred from the villages.

Primary Health Centres :

(a) Number of male and female doctors sanctioned and in position.

(b) Number of nurses and other paramedical staff sanctioned and in position.

(c) Number of vehicles given to PHC and available in working order, if not available or not in working order, the dates since when the same have not been available or not in working order,.

(d) The stock of vaccines and the record of breakdown of Cold Chain equipment during the last one month.

(e) Whether an Operation Theatre is available and if so the availability of equipments and the quality of maintenance.

(f) Number of male and female sterilization operations, IUD insertions and MTP operations undertaken during the last one month.

(g) Number of deliveries conducted in the PHC during last one month.

Sub-Centre :

(a) Whether the sub-centre office is centrally set up. Whether it is in a Government building and what is the general condition of the facilities in the sub-centre.

(b) What is the availability of ANM and Male Multi-purpose Workers in the sub-centre and whether they attend office regularly.

(c) Whether all the stocks of drugs and vaccines are available in the sub-centre and is the arrangement for their storage satisfactory.

(d) Whether ANM and Male Multi-purpose Workers are maintaining upto date records.

(e) IUD insertions made and deliveries conducted by the ANM during the last one and three months.

(f) General comments about the adequacy of work done by ANM and Male Multi-purpose Workers along with a brief account of difficulties experienced.

User Satisfaction :

(To visit two villages out of which at least one should be at least

10 KM away from Block Headquarters in one of the sub-divisions of the District. Also similar visits have to be made to at least one Municipal ward preferably with a population of poorer sections of the community).

(a) To ascertain from some women who may have delivered recently whether three prenatal and three postnatal checks were made by the ANM. Also to ascertain whether anti tetanus immunization was given.

(b) To ascertain whether delivery was institutional or by a trained birth attendant or by untrained birth attendant. In case it was with the help of untrained birth attendant, to ascertain why institution or ANM was not approached.

(c) To ascertain immunization status of children below 5 years.

(d) To ascertain availability of contraceptives meant either for free distribution or social marketing.

(e) To ascertain whether their needs are being attended to in a courteous manner when they approach the ANM/PHC or FRU and whether ANM or Male Multi-purpose Health Worker is approaching them to ascertain their needs and to provide counselling.

The National level nodal agency as well as each of the collaborating institutions will be selected in accordance with the World

Bank procedures. Such institutions may be either a Government supported institution (in which case it will be provided actual costs under IDA funds and the consultancy charges will be paid by the Department separately) or a non-government institution in which case actual expenses and consultancy charges will be paid out of IDA funds.

III. Inspection

There is a need to have inspection at every level of functionary or institution. Every institution or worker must be inspected by the superior officer in the district with regularity to ensure that work is getting done. It should be realised that periodic reporting by subordinate officers is not a substitute for inspection by superior officers. The reports always have the weakness that reporting officials will naturally avoid mentioning shortcomings and will only highlight or even exaggerate achievements. Inspections on the other hand provide opportunity to superior officers to see for themselves, firsthand, both the shortcomings and achievements. They also provide opportunity to provide guidance to subordinate officials and for discussion of difficulties.

A district officer should inspect a minimum of one sub-district hospital, one PHC; one ANM and one village optimally this must be done every month.

While it is for the state government to give detailed instructions

about inspections to be made at various levels, the rural sub-centre and PHC being the crucial units for the family welfare work some essential points to be pointedly attended to in their inspection are enumerated below.

During inspection of sub-centre the following points should receive priority attention :

1. The availability of the ANM at sub-centre. Whether ANM and male health worker living in headquarter or not. What is the arrangement for and condition of sub-centre office.

2. Are the health workers maintaining office on fixed day of week. (Check from record of work done)

3. Whether ANM has mother and child cards and registers with her.

4. Upto dateness of records by ANM and male health worker.

5. Whether sessions held with
   - Anganwadi worker
   - Panchayat members
   - Mahila Swasthya Sangh
   - Trained birth attendant (TBA)

6. Whether she has sufficient quantities of Vitamin A, IFA tablets, ORS packets, Cotrimoxazole tablets.

7. Whether the total number of cases of vaccines and drugs recorded as administered are tallying with the stock position shown as used up. If this is verified this will ensure only as much as drugs and vaccine as required will be indented. Since it has been noted in the past that the quantity reported used was sometimes much more than the stock used.

8. Whether the ANM carries the vaccine in cold chain and has enough syringes and needles so that she can use one syringe and one needle for every beneficiary after ensuring proper sterilization.
9. Number of deliveries conducted by ANM.
10. Number of deliveries and child diseases referred to PHC/FRU.
11. Number of cases of RTI/STI detected and referred to PHC/FRU by ANM and male health worker.
12. Whether Male Health Worker assists the ANM at immunization sessions.
13. Whether Male health worker motivates males for permanent methods i.e. vasectomy and use of condoms.
14. Whether community needs assessment has been done on time and whether monthly report sent in time or not. If not why not?

Medical Officers of PHC

1. The availability of the doctors and paramedical staff against sanctioned post for that particular PHC.

2. What is the condition of the building and facilities of PHC; specifically arrangements for water and electricity and state of cleanliness.

3. If there is an operation theatre, what is its condition and availability of equipment.

4. Figures for following items to be obtained pertaining to work done at PHC.

   - No. of high risk referral cases seen – both women and children.
   - No. of deliveries conducted.
   - No. of MTP conducted.
   - No. of RTI/STI cases treated.
   - No. of immunizations done.
   - No. of cases of diarrhoea treated.
   - No. of cases of ARI treated.
   - No. of IUD insertions done.
   - No. of sterilization operations performed both – male and female.

5. Whether the Community Needs Assessment has been done on time and whether monthly report sent in time or not. If not – why not ?

(To be submitted by 10th March to the PHC)

FORM 1

SUB-CENTRE (S.C.) ACTION PLAN

A. General Information _____
State _____
District _____
P.H.C. _____
Sub-centre _____
No. of Villages
under the sub-centre

Year _____
Population of S.C._____
Birth Rate)Distt./State _____ _____
Eligible couples _____
(As on 1st April)

ANC = (Population x Birth rate) + 10% DELIVERY/LIVE BIRTH = (Population x Birth rate).

Sl. No.	Consultation with	No. of Consultation	When consultation made (month of year)
1.	Panchayat or health committee of the Panchayat		
2.	Anganwadi worker / TBA		
3.	Women in Mahila Swasthya Sangh		
4.	Families on house to house basis		

Sl. No.	Service	Performance in last year	Planned performance in current year
	Antenatal Care		
1.	Total ANC cases registered in the area		
2.	No. of high risk pregnant women detected and referred		
3.	No. of TT doses given TT1 TT2 Booster		
4.	No. of pregnant women with anaemia treated		
5.	No. of pregnant women given prophyaxis with IFA tablets.		
	Natal Care		
6.	Total no. of deliveries in the area		
7.	No. of home delivery by a) ANM / LHV b) Trained birth attendant		
8.	No. of institutional deliveries		
9.	No. of pregnant women referred to PHC / FRU for delivery		
	Neo-Natal care		
10.	No. of sick new borns referred		
	MTP		
11.	No. of women referred for MTP		

Sl. No.	Service	Performance in last year		Planned performance in current year	
		Male	Female	Male	Female
	RTI / STI				
12.	No. of cases detected & referred				
	Immunisation				
13.	No. of infants immunised (0 -1 year)				
	BCG				
	DPT-1				
	DPT-2				
	DPT-3				
	OPV-0				
	OPV-1				
	OPV-2				
	OPV-3				
	Measles				
14.	No. of children immunised (more than 18 months)				
	DPT Booster				
	OPV Booster				
15.	No. of children immunised (more than 5 years)				
	DT				
16.	No. of children immunised (more than 10 years)				
	TT				
17.	No. of children immunised (more than 16 years)				
	TT				
	IFA				
18.	No. of children given IFA small (below 5 years)				
19.	No. of children administered Vit-A (9 months to 3 years)				
	Dose 1				
	Dose 2				
	Dose 3 - 5				
	ARI				
20.	No. of cases under 5 with pneumonia				
	- Treated with co-trimoxozole				
	- Referred				
	Acute diarrhoeal diseases				
21.	No. of cases under 5				
	- Cases treated with ORS				
	- Referred				
	Family Planning				
22.	No. of elegible couples who accepted permanent methods out of couples with				
	a) 3 or more children				
	b) 2				
	c) 1 child				
23.	No. of eligible couples who accepted temporary methods				
	- IUD				
	- Oral Pills				
	- Condoms				

INVENTORY OF VACCINES AND DRUGS

(Form 1 contd.)

Sl. No.	Item	Unit	Requirement assessed last year	Actual quantity received last year	Surplus or shortage last year	Requirement for current year
1.	ORS Packets					
2.	Metronidazole Tablets					
3.	Co-trimoxazole					
4.	Paracetamol					
5.	Chloroquine					
6.	Antiseptic solution					
7.	Uristix					
8.	DD kits (Disposable Delivery Kits)					
9.	Slides for blood tests					
10.	Thermometer					
11.	Gloves					
12.	IFA large					
13.	IFA small tablets					
14.	Vit-A solution					
15.	Condom					
16.	Oral pills					
17.	IUDs					
18.	Syringe & Needles					

FACILITY IN SUB-CENTRE

Sl. No.	Selected equipment and supplies	Available		Quantity / quality
		Yes	No	
A.	**Facilities**			
1.	Officer			
2.	Accomodation (including residence)			
3.	Water			
4.	Electricity			
B.	**Furniture & Equipment**			
1.	Examination table			
2.	Benches for clients			
3.	Cupboard for drugs			
4.	Foot Stools			
5.	Vessells for Water storages			
6.	Water disposal containers			
7.	Brooms and mops for cleaning			
8.	Steam sterilizer			
9.	Delivery kits			
10.	Torch light			
11.	Stove			
12.	Weighing scale			
13.	BP Apparatus			
14.	Haemoglobinometer			
15.	Vaccine carrier			
16.	IUD kits			
C.	**IEC Material**			
17.	Posters			
18.	Models			
19.	Flip Chart			

Signature (ANM)

To be submitted by 15th March to the District Family Welfare Officer for data-entry in NIC-District Computer)

FORM 2

PHC ACTION PLAN

A. General information _____

State _____

District _____

P.H.C. _____

No. of sub-centres under PHC _____

Population of PHC (Total of population under sub-centres) _____

Year _____

Birth Rate _____

(District / State) _____

Eligible couples _____
(As on 1st April)

S.No.	Services	Performance in last year	Planned performance in current year compiled from sub-centre plans
	Antenatal Care		
1.	Total ANC cases registered in the PHC area		
2.	No. of high risk pregnant women - Treated - Referred to FRU		
3.	No. of TT doses given TT1 TT2 Booster		
4.	No. of pregnant women with anaemia treated		
5.	No. of pregnant women given prophylaxis with IFA tablets		
	Natal Care		
6.	Total no. of deliveries in the PHC area		
7.	No. of home deliveries by a) ANM / LHV b) Trained birth attendant c) Untrained birth attendant		
8.	No. of institutional deliveries a) At PHC b) At Sub-centre		
9.	No. of pregnant women referred to FRU for delivery.		
	Neo-natal Care		
0.	No. of sick new born referred - Treated - Referred		
1.	**MTP**		
2.	No. of MTPs referred to FRU / District		

S.No.	Service	Performance in Last Year		Expected Requirement for current year	
		Male	Female	Male	Female
	RTI / STI				
13.	No. of cases				
	a) Identified by ANM				
	b) Dealt with at PHC				
	i) Treated				
	ii) Referred				
	Immunization				
14.	No. of infants immunized (0-1 years)				
	BCG				
	DPT-1				
	DPT-2				
	DPT-3				
	OPV-0				
	OPV-1				
	OPV-2				
	OPV-3				
	Measles				
15.	No. of children immunized (more than 18 months)				
	DPT Booster				
	OPV Booster				
16.	No. of children immunized (more than 5 years)				
	DT				
17.	No. of children immunized (more than 10 years				
	TT				
18.	No. of children immunized (more than 16 years)				
	TT				
	IFA				
19.	No. of children given IFA small (below 5 years)				
	Vit. A				
20.	No. of children administered Vit-A (9 months to 3 years)				
	a) Dose 1				
	b) Dose 2				
	c) Dose 3-5				
21.	**ARI**				
	No. of cases under 5 with pneumonia				
	a) Identified by ANM				
	b) Attended at PHC				
	(i) Treated with cotrimoxozole				
	(ii) Referred				

(Form 2 contd.)

S.No.	Service	Performance in Last year		Expected Requirement for current year	
		Male	Female	Male	Female
	Acute diarrhoeal / diseases				
22.	No. of cases under 5				
	a) Identified by ANM				
	b) Attended at PHC				
	(i) Treated with ORS				
	(ii) Referred				
	Family Planning				
23.	Male sterilisation				
	a) Conventional				
	b) NSV				
24.	Female sterilisation				
	a) Abdominal				
	b) Laproscopic				
25.	IUD Insertion				
	a) By ANMs				
	b) By PHC				
26.	Oral Pill users				
27.	Condom users				

Materials & Supplies

Sl. No.	Items	Quantity used in previous year	Stock position on 1st April	Additional quantity required in current year
	Contraceptives			
1.	Nirodh Pieces			
2.	Oral Pill Cycles			
3.	IUDs			
4.	Tubal Rings			
5.	Dai Kits			
	Vaccine Doses			
6.	DPT			
7.	OPV			
8.	TT			
9.	BCG			
0.	Measles			
1.	DT			
	Prophylactic Drugs			
2.	IFA Tab. Large			
3.	IFA Tab. Small			
4.	Vit. A Solution			
5.	ORS Packets			
	Cotrimoxazole			
6.	Tablet Paediatric			

Equipments & Facilities

1. PHC Building Owned or Rented :

Sl. No.	Items	No. Available	No. Functioning
1.	Vehicle		
2.	Refrigerator		
3.	ILR		
4.	Deep Freezer		
5.	Cold Box		
6.	Vaccine / Day Carrier		
7.	X-Ray machine		
8.	IUD Kits		
9.	Examination Table		
10.	Weighing Machine (Infant)		
11.	B.P. Instrument		
12.	Stethoscope		
13.	Needles		
14.	Syringes		
15.	Autoclave		
16.	Steam Sterilizer Drugs		
17.	Operation Theatre		
18.	MTP Suction Aspirators		
19.	Equipment for Infant Resucitation		
20.	Microscope & Lab. Equipment		
21.	Oxygen Cylinder		
22.	Labour Room Table & Equipment		
23.	O.T. Table		
24.	Surgical Equipments relating to PHC expertise		

STAFF POSITION

(Form 2 contd.)

Sl. No.	Category of Staff	Number sanctioned	Number in position	Number vacant since that date
1.	Medical Officer-1			
2.	Medical Officer-2			
3.	Lady Medical Officer			
4.	Dental Surgeon			
5.	Staff Nurse / Nurse Midwife			
6.	Pharmacist / Compounder			
7.	Lab. Technical / Lab. Asstt.			
8.	Radiographer			
9.	Computer			
10.	Malaria Supervisor			
11.	Block extn. Educator			
12.	Public Health Nurse			
13.	Lady Health Visitor			
14.	Driver			
15.	Multi Purpose Worker - Male			
16.	Multi Purpose Worker - Female			
17.	Class - IV Staff			

Sign. (MO / PHC)

(To be submitted by 20th March to the District Family Welfare Officer for data-entry in NIC-District Computer))

FORM 3

FRU ACTION PLAN

A. General Information _____

State _____

District _____

FRU _____

No. of PHC under the FRU _____

Population under the FRU _____

Birth Rate of District / State _____

Year _____

Ellgible couples _____

(As on 1st April) _____

Sl. No.	Services	Performance in last year from PHC plans	Planned performance in next year as compiled
	Antenatal Care		
1.	Total No. of ANC cases registered at the FRU		
2.	No. of high risk women - TREATED		
3.	No. of TT doses given TTI TT2 Booster		
4.	No. of pregnant women with anaemia treated		
5.	No. of pregnant women given prophylaxis with IFA tablets		
	Natal Care		
6.	Total No. of deliveries in the District		
7.	No. of home deliveries by a) ANM / LHV b) Trained birth attendant c) Untrained birth attendant		
8.	No. of institutional deliveries a) At District hospitals b) At FRU c) At PHC d) At sub-centres		
9.	No. of pregnant women referred to District Hospitals		

	Neonatal Care				
10.	No. of sick new borns treated				
11.	No. of sick new borns referred to District Hospital				
12.	**MTP**				
	Total no. of MTPs done				
	a) referral cases				
	b) direct cases				
	RTI / STI	**M**	**F**	**M**	**F**
13.	No. of cases				
	a) Indentified				
	b) Treated				
	c) Referred to District hospital				
	IMMUNIZATION				
14.	No. of infants immunized (0 -1 years)				
	BCG				
	DPT-1				
	DPT-2				
	DPT-3				
	OPV-0				
	OPV-1				
	OPV-2				
	OPV-3				
	Measles				
15.	No. of children immunized (more than 18 months)				
	DPT Booster				
	OPV Booster				
16.	No. of children immunized (more than 5 years)				
	DT				
17.	No. of children immunized (more than 10 years)				
	TT				
18.	No. of children immunized (more than 16 years)				
	TT				
	IFA				
19.	No. of children given IFA small (below 5 years)				

		M	F	M	F
	Vit. A				
20.	No. of children administered Vit. A (9 months to 3 years)				
	a) Dose 1				
	b) Dose 2				
	c) Dose 3 - 5				
	ARI				
21.	No. of cases under 5 with pneumonia				
	a) Treated with cotrimoxozole				
	b) Referred to District Hospital				
	Acute Diarrhoeal Diseases				
22.	No. of cases under 5				
	a) Treated with ORS				
	b) Referred to District Hospital				
	Family Planning				
23.	Male Sterilisation				
	a) Conventional				
	b) NSV				
24.	Female Sterilisation				
	a) Abdominal				
	b) Laparoscopic				
25.	IUD Insertion				
	a) By ANM				
	b) By PHC doctor				
	c) By FRU doctor				
26.	Oral Pill Users				
27.	Condom Users				

(Form 3 contd.)

MATERIAL & SUPPLIES

Sl. No.	Items	Unit	Qty. used in previous year	Stock position on 1st April	Additional Quantity required in current year
	Contraceptives				
1.	Nirodh pieces				
2.	Oral pill Cycles				
3.	IUDs				
4.	Tubal rings				
5.	Dai kits				
	Vaccine Doses				
6.	DPT				
7.	OPV				
8.	TT				
9.	BCG				
10.	Measles				
11.	DT				
	Prophylactic Drugs				
12.	IFA Tab. large				
13.	IFA Tab. small				
14.	Vit. A solution				
15.	ORS Packets				
	Cotrimoxazole				
16.	Tab. Paediatric				
17.	RTI / STI Drugs				

Equipment and Facilities

S.No.	Item	Available (No.)	Functioning (No.)
1.	Vehicles		
2.	Computers		
3.	Photocopiers		
4.	X-ray Machines		
5.	Cold Chain Equipment - ILR - 300 - DF2 - 300 - ILR - 140 - DR2 - 140		

Staff Position

S. No.	Category	Sanctioned (No.)	Vacant (No.)
1.	Specialist in FRU / District / CHC		
2.	Doctors in PHC		
3.	ANMs in Sub-centre		
4.	Male Health Workers		

Signature of D.M.O.

(To be submitted by 25th March to the State Family Welfare Officer and Deptt of Family Welfare, MOHFW, GOI, New Delhi through NICNET)

FORM 4
DISTRICT ACTION PLAN

A. General Information _____

State _____ Code : ☐

District _____ Code : ☐

No. of PHC in that District _____

Population of the District _____

Birth Rate of District / State _____

Year _____

Eligible couples _____

(as on 1st April) _____

Sl. No.	Services	Performance in last year	Planned performance in current year as compiled from PHC & FRU plans
	Antenatal Care		
1.	Total No. of ANC cases registered in the Distt.		
2.	No. of high risk pregnant women - Treated		
3.	No. of TT dose given TT1 TT2 Booster		
4.	No. of pregnant women with anaemia treated		
5.	No. of pregnant women given prophylaxis with IFA tablets		
	Natal Care		
6.	Total No. of deliveries in the District		
7.	No. of home deliveries by a) ANM / LHV b) Trained birth attendant c) Untrained birth attendant		
8.	No. of institutional deliveries a) At District hospital b) At FRU c) At PHC d) At sub-centre		
	Neonatal Care		
9.	No. of sick new borns - Treated - Referred		
	MTP		
10.	No. of MTPs done		

		M	F	M	F
	RTI / STI				
11.	No. of cases detected				
	- Treated				
	- Referred				
	Immunization				
12.	No. of infants immunized (0-1 years)				
	BCG				
	DPT-1				
	DPT-2				
	DPT-3				
	OPV-0				
	OPV-1				
	OPV-2				
	OPV-3				
	Measles				
13.	No. of children immunized (more than 18 months)				
	DPT Booster				
	OPV Booster				
14.	No. of children immunized (more than 5 years) DT				
15.	No. of children immunized (more than 10 years) TT				
16.	No. of children immunized (more than 16 years) TT				
17.	No. of children given IFA small (below 5 years)				
	Vit. A				
18.	No. of children administered Vit. A (9 months to 3 years)				
	a) Dose 1				
	b) Dose 2				
	c) Dose 3 - 5				
	ARI				
19.	No. of cases under 5 with pneumonia				
	a) Treated with cotrimoxazole				
	b) Referred				
	Acute Diarrhoeal diseases				
20.	No. of cases under 5				
	Treated with ORS				

	Family Planning		
21.	Male Sterilisation a) Conventional b) NSV		
22.	Female Sterilisation a) Abdominal b) Laparoscopic		
23.	IUD Insertion a) By ANM b) By PHC doctor c) By FRU doctors d) By District hospital doctors		
24.	Oral Pill Users		
25.	Condom Users		

Material & Supplies

Sl. No.	Items	Unit	Qty. used in previous year	Stock position on 1st April	Additional Quantity required in
	Contraceptives				
1.	Nirodh pieces				
2.	Oral Pill Cycles				
3.	IUDs				
4.	Tubal rings				
5.	Dai Kits				
	Vaccine Doses				
6.	DPT				
7.	OPV				
8.	TT				
9.	BCG				
10.	Measles				
11.	DT				
	Prophylactic Drugs				
12.	IFA Tab. large				
13.	IFA Tab. small				
14.	Vit. A solution				
15.	ORS Packets				
	Cotrimoxazole				
16.	Tab. Paediatric				
17.	RTI / STI Drugs				

Equipment and Facilities

Sl. No.	Item	Available (Number)	Functioning (Number)
1.	Ambulance		
2.	B.P. Apparatus		
3.	Weighing Machine		
4.	Microscope & Lab Equipment etc.		
5.	Autoclave		
6.	Oxygen Cylinder		
7.	MTP Suction Apparatus		
8.	ILR		
9.	Deep Freezer		
10.	Cold Box		
11.	Refrigerator		
12.	X-Ray Machine		
13.	Laproscope		
14.	Kit E - haparotomy set		
15.	Kit F - Min haparatomy set		
16.	Kit G - IUD insertion set		
17.	Kit H- Vasectomy set		
18.	Kit I - Normal delivery set		
19.	Kit J - Vacuum extraction set		
20.	Kit K - Embryotomy set		
21.	Kit L - Uterine evacuation set		
22.	Kit M - Equipment for anaesthesia		
23.	Kit N - Neonatal resucitation set		
24.	Kit O - Equipment and Reagents for blood tests		
25.	Kit P - Donor blood transfusion set		

Staff Position

(Form 4 contd.)

Sl. No.	Category of Staff	Sanctioned (Number)	In position (Number)	Vacant since what date (Number)
1.	Medical Officer			
2.	Specialist a) Anaesthetist b) Gynaecologist c) Paediatrician d) Pathologist e) Dental Surgeon			
3.	Staff Nurses / Nurse Midwife			
4.	Pharmacist / Compounder			
5.	Lab. Tech. / Lab Asstt.			
6.	Radiographer			
7.	Computer			
8.	Driver			
9.	Paramedical Supervisors - Malaria Inspector - BEE - PHN / LHV - HA			
10.	Multipurpose worker - Male - Female			

Signature of D.M.O.

(To be submitted by 25th March by the State Family Welfare Officer to the Deptt. of Family Welfare, MOHFW, GOI, New Delhi through NICNET)

FORM 5
STATE ACTION PLAN

A. General Information _____

State _____ Code : ☐ Year _____

No. of District in that State _____ Eligible couples _____

Population of the State _____ (As on 1st April) _____

No. of District Action plan received _____

Birth Rate of State _____

Sl. No.	Services	Performance in last year	Planned performance in current year as compiled from District plans
	Antenatal Care		
1.	Total No. of ANC cases registered in the State		
2.	No. of high risk pregnant women - Treated		
3.	No. of TT doses given TT1 TT2 Booster		
4.	No. of pregnant women with anaemia treated		
5.	No. of pregnant women given prophylaxis with IFA tablets.		
	Natal Care		
6.	Total No. of deliveries in the State		
7.	No. of home deliveries by a) ANM / LHV b) Trained birth attendant c) Untrained birth attendant		
8.	No. of institutional deliveries a) At district hospital b) At FRU c) At PHC d) At sub -centre		
	Neonatal Care		
9.	No. of sick new borns - Treated - Referred		
	MTP		
10.	No. of MTPs done		

	RTI / STI	M	F	M	F
1.	No. of cases detected - Treated - Referred				
	Immunization				
2.	No. of infants immunized (0 -1 years) BCG DPT-1 DPT-2 DPT-3 OPV-0 OPV-1 OPV-2 OPV-3				
	Measles				
13.	No. of children immunized (more than 18 months) DPT Booster OPV Booster				
14.	No. of children immunized (more than 5 years) DT				
15.	No. of children immunized (more than 10 years) TT				
16.	No. of children immunized (more than 16 years) TT				
17.	No. of children given IFA small (below 5 years)				
	Vit. A				
18.	No. of children administered Vit. A (9 months to 3 years) a) Dose 1 b) Dose 2 c) Dose 3 - 5				
	ARI				
19.	No. of cases under 5 with pneumonia a) Treated with cotrimoxozole b) Referred				
	Acute Diarrhoeal diseases				
20.	No. of cases under 5 Treated with ORS				

	Family Planning		
21.	Male Sterilisation a) Conventional b) NSV		
22.	Female Sterilisation a) Abdominal b) Laparoscopic		
23.	IUD Insertion a) By ANM b) By PHC doctor c) By FRU doctors d) By District hospital doctors		
24.	Oral Pill Users		
25.	Condom Users		

Material & Supplies

Sl. No.	Item	Unit	Qty. used in previous year	Stock position on 1st April	Additional quantity required in current year
	Contraceptives				
1.	Nirodh pieces				
2.	Oral Pill Cycles				
3.	IUDs				
4.	Tubal rings				
5.	Dai Kits				
	Vaccine Doses				
6.	DPT				
7.	OPV				
8.	TT				
9.	BCG				
10.	Measles				
11.	DT				
	Prophylactic Drugs				
12.	IFA Tab. large				
13.	IFA Tab. small				
14.	Vit. A solution				
15.	ORS Packets				
	Co-trimoxazole				
16.	Tab. Paediatric				
17.	RTI / STI Drugs				

Equipment and Facilities

(Form 5 contd.)

S.No.	Item	Available (No.)	Functioning (No.)
1.	Vehicles		
2.	Computer		
3.	Photocopiers		
4.	X-Ray Machines		
5.	Cold Chain Equipment - ILR-300 - DF2 - 300 - ILR - 140 - DR2 - 140		

Staff Position

S.No.	Category	Sanctioned (No.)	Vacant (No.)
1.	Specialists in FRU / District / CHC		
2.	Doctors in PHC		
3.	ANMs in Sub-centre		
4.	Male Health Workers		
5.	Lady Health Visitor		

Signature of S.F.W.O.

(To be submitted by 15th of the following month to PHC)

FORM 6

MONTHLY REPORT FOR SUB-CENTRE / URBAN HEALTH POST / REVAMPING CENTRE (REPORT OF ANM / MPW (MALE)

General Information

1. State : _____
2. District : _____
3. PHC : _____
4. Sub-Centre : _____
5. Population of PHC : _____
6. Population of Sub-centre : _____
7. Reporting for the month of : _____
8. Eligible Couples (as on 1st April of the year) : _____

Sl. No.	Services	Performance in corresponding month last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
	Ante Natal Care					
1.	Ante Natal Cases Registered					
	a) Total					
	b) Less than 12 weeks					
2.	No. of pregnant women who had 3 check-ups					
3.	Total No. of high risk pregnant women referred					
4.	No. of TT doses					
	a) TT1					
	b) TT2					
	c) Booster					
5.	No. of pregnant women under treatment for anaemia					
6.	No. of pregnant women given prophylaxis for anaemia					

2.	**Natal Care**									
2.1	Total No. of deliveries									
2.2	Home deliveries									
	a) (i) by ANM									
	(ii) by LHV									
	b) by trained Birth Attendant									
	c) Untrained Birth Attendant									
2.3	Deliveries at Sub-Centre									
2.4	Complicated deliveries referred to PHC/FRU	M	F	M	F	M	F	M	F	
3.	Pregnancy Outcome									
3.1										
	a) Live births									
	b) Still births									
3.2	Order of Birth in 3.1 (a)									
	a) 1st									
	b) 2nd									
	c) 3rd									
3.3	New born status at birth									
	a) Less than 2.5 Kg.									
	b) 2.5 Kg. or more									
	c) No. of high risk new borns referred to PHC / FRU									
4.	Post Natal Care									
4.1	No. of women given 3 post natal check-ups									
4.2	Complications referred to PHC / FRU									
5.	Maternal Deaths									
5.1	During pregnancy									
5.2	During delivery									
5.3	Within 5 weeks of delivery									
6.	RTI / STI									

(Form 6 contd.)

6.1	Cases	M	F	M	F	M	F	M	F	
	a) Detected									
	b) Treated									
	c) Referred									
7.	Immunization									
7.1	Infant 0 to 1 year									
	BCG									
	DPT1									
	DPT2									
	DPT3									
	OPV0									
	OPV1									
	OPV2									
	OPV3									
	Measles									
7.2	Children more than 18 months									
	DPT Booster									
	OPV Booster									

	Full Immunization										
7.3	Children more than 5 years										
	DT										
7.4	Children more than 10 years										
	TT										
7.5	Children more than 16 years										
	TT										
7.6	**Adverse reaction reported after Immunization**										
8.	Vitamin A administration (9 months to 3 years)										
	Dose 1										
	Dose 2										
	Dose 3 - 5										
9.	Childhood Diseases										
9.1	Vaccine preventable diseases										
	a) Diptheria										
	i) Cases detected										
	ii) Treated										
	iii) Referred										
	iv) Deaths										
	b) Poliomyalitis (AFP)										
	i) Cases detected										
	ii) Treated										
	iii) Referred										
	iv) Deaths										

9.2	c) Neo Natal Tetanus										
	i) Cases detected										
	ii) Treated										
	iii) Referred										
	iv) Deaths										
	d) Measles										
	i) Cases detected										
	ii) Treated										
	iii) Referred										
	iv) Deaths										
9.3	ARI under 5 years (Pneumonia)										
	a) Treated with Co-trimoxozole										
	b) Referred to PHC / FRU										
	c) Deaths										
9.4	Acute Diarrhoeal diseases under 5 years										
	a) Treated with ORS										
	b) Referred to PHC / FRU										
	c) Deaths										
10.	Child Deaths										
	a) Within 1 week										
	b) 1 week to 1 month										
	c) 1 month to 1 year										
	d) 1 year to 5 years										

11.	Contraceptive Service						
11.1	Eligible couples contacted						
11.2	Male sterilisation						
	a) Total no. of cases motivated						
	b) No. of cases followed up						
11.3	Female sterilisation						
	a) Total No. of cases motivated						
	b) No. of cases followed up						
11.4	Total IUD insertions						
	a) Cases followed up						
	b) Complication						
	c) Discontinued						
	i) Removed						
	ii) Expelled						
11.5	Total Oral Pill users						
	a) Old Users						
	b) New Users						
	c) Complications						
	d) Discontinued						
11.6	Total condom users						
12.	Abortions						
	a) No. of women referred for MTP						
	b) No. of MTP done						
	c) Cases followed up						
	d) Complications						
	e) Deaths						

(Form 6 contd.)

13.	Communicable Diseases						
13.1	Malaria						
	a) No. of fever identified						
	b) No. of blood smear slides sent to PHC						
	c) No. of fever cases given presumptive treatment						
	d) No. of positive cases of malaria						
	e) No. of positive cases given radical treatment						
	f) No. of anti-mosquito activities co-ordinated						
	g) No. of high risk villages identified						
13.2	Tuberculosis						
	a) No. of suspected cases						
	i) Identified						
	ii) Referred						
	b) No. of sputum positive cases						
	c) No. of TB cases followed up						

IV Interaction with Community

Serial No.	Meeting with	No. of Meetings
1.	Panchayat Health Committee	
2.	Mahila Swasthya Sangh	
3.	Anganwadi Workers	

(Form 6 contd.)

V. MONTHLY STOCK POSITION

Sl. No.	Item	Opening Balance	Received	Total	Consumption	Balance	Requirement
1.	IFA Large						
2.	IFA small						
3.	Vitamin A						
4.	Co-trimoxozole						
5.	ORS packets						
6.	Methylergometrine						
7.	Cholorophenaramine						
8.	Paracetamol						
9.	Anti-spasmodic tablets						
10.	Inj. Methylergometrine						
11.	Mebendazole						
12.	Syringes & Needles						
13.	Vaccine day carrier						
14.	Steriliser / Autoclave						
15.	Chloramphenicol						
16.	Cetrimide power						
17.	Povidone ointment 5%						
18.	Cotton bandage						
19.	Contraceptives a) Nirodh b) Oral Pills c) IUDs						
20.	Disposable delivery kit						
21.	Chloroquine Tab.						

VACCINE RECEIVED FROM PHC

(Form 6 contd.)

Sl. No.	Name of Vaccine weekly session 1 Date / Dose	Vaccine received for weekly session 2 Date / Dose	Vaccine received for weekly session 3 Date /Dose	Vaccine received for weekly session 4 Date / Dose	Vaccine received for weekly	Vaccine received	Total
1.	DPT						
2.	OPV						
3.	DT						
4.	TT						
5.	BCG						
6.	Measles						

Last training attended (mention month & year) :

Date of inspection made in reporting month by :

i) MPW (Male)

ii) MPW (Female / ANM)

LHV _____

MO (PHC) _____

BEE _____

DMO _____

A note on the progress made as well as the handicap or achievement experienced in the field either because of shortage of essential supplies, vaccines of personnel essential to the programme and resistance encountered on account of social and cultural beliefs.

(Do not use more than this space)

Signature ANM

Signature (Male Health Worker)

(To be submitted by 20th of following month to District Family Welfare Officer for Data Entry in NIC-District Computer)

FORM 7
MONTHLY REPORT FROM PHC / URBAN DISPENSARY TO DISTRICT
(REPORT OF MEDICAL OFFICER)

I. General

1. State : _____
2. District : _____
3. PHC : _____
4. Population of PHC : _____
5. Reporting for the month of : _____
6. Eligible Couples (as on 1st April of the year) : _____

II. Services

Sl. No.	Services	Performance in corresponding month last year	Performance in the reporting month	Cumulative performance till corresponding month of last year	Cumulative performance till current month	Planned performance in current year
1.	**Ante Natal Care**					
1.1	Ante Natal Cases Registered					
	a) Total					
	b) Less than 12 weeks					
1.2	No. of pregnant women who had 3 check-ups					
1.3	Total No. of high risk pregnant women attended					
	Attended and Treated at PHC					
	Referred to FRU					
1.4	No. of TT doses					
	a) TT1					
	b) TT2					
	c) Booster					
1.5	No. of pregnant women under treatment for anaemia					
1.6	No. of pregnant women given prophylaxis for anaemia					
2.	Natal Care					
2.1	Total No. of deliveries					

2.2	Home Deliveries										
	a) By ANM / LHV										
	b) By trained Birth Attendant										
	c) Untrained Birth attendant										
2.3	Institutional deliveries (Total)										
	a) at PHC										
	b) at Sub-Centres										
2.4	Deliveries referred to FRU										
3.	Pregnancy Outcome	M	F	M	F	M	F	M	F		
3.1	No. of births										
	a) Live births										
	b) Still births										
3.2	Order of Birth in 3.1 (a)										
	a) 1st										
	b) 2nd										
	c) 3+										
3.3	New born status at birth										
	a) Less than 2.5 Kg.										
	b) 2.5 Kg. or more										
	c) No. of high risk new borns referred to FRU										
4.	**Post Natal Care**										
4.1	No. of women given 3 post natal check-ups										
4.2	Complications referred to FRU										
5.	**Maternal Deaths**										
5.1	During pregnancy										
5.2	During Delivery										
5.3	Within 6 weeks of delivery										
6.	**RTI / STI**	M	F	M	F	M	F	M	F		
6.1	Cases detected and treated										
6.2	Cases referred to FRU										
7.	**Immunization**										
7.1	Infant 0 to 1 year										
	BCG										
	DPT 1										

	DPT 2										
	DPT 3										
	DPT BOOSTER										
	OPV 0										
	OPV 1										
	OPV 2										
	OPV 3										
	MEASLES										
7.2	Children more than 18 months										
	DPT Booster										
	OPV Booster										
	Full Immunization										
7.3	Children more than 5 years										
	DT										
7.4	Children more than 10 years										
	TT										
7.5	Children more than 16 years										
	TT										
	Adverse reactions reported after Immunization										
8.	Vitamin A administration (9 months to 3 years)										
	Dose 1										
	Dose 2										
	Dose 3-5										
9.	Childhood Diseases										
9.1	**Vaccine preventable diseases**										
	a) Diptheria										
	Cases										
	Deaths										
	b) Poliomyelitis (Acute Flaccid Paralysis)										
	Cases										
	Deaths										
	c) Neo Natal Tetanus										
	Cases										
	Deaths										

	d) Tetanus other than Neo Natal									
	Cases									
	Deaths									
	e) Whooping cough									
	Cases									
	Deaths									
	f) Measles									
	Cases									
	Deaths									
9.2	ARI under 5 years (Pneumonia)									
	a) Cases									
	b) Treated with Co-trimoxozole									
	c) Referred									
	d) Deaths									
9.3	Acute Diarrhoeal diseases under 5 years									
	a) Cases									
	b) Treated with ORT									
	c) Referred to PHC / FRU									
	d) Deaths									
10.	**Child Deaths**									
	a) Within 1 week									
	b) 1 week to 1 month									
	c) 1 month to 1 year									
	d) 1 year to 5 years									
11.	**Contraceptive Services**									
11.1	Eligible couples contacted									
11.2	Male Sterilisation									
	a) Conventional									
	b) Non Scalpel									
11.3	Total IUD insertions									
	a) Cases followed up									
	b) Complications									
	c) Discontinued									

11.4 Total Oral Pill users						
a) Old users						
b) New users						
c) Complications						
d) Discontinued						
11.5 Total condom users						

12. **Abortions**									
a) Spontaneous									
b) No. of MTPs at PHC									
c) Cases followed up									
d) Complications									
e) Deaths									

III. FACILITIES :

1. Transport :

a) Vehicle :

Total : _____ On Road : _____

2. X-ray Machine

Available : Yes _____ No. _____ Working : Yes _____ No _____

3. Status of cold chain equipments :

Equipment	Total Supplied	Total Working	No. not working for more than a month
ILR - 300 D.F.Z - 300 ILR - 140 D.F.Z - 140			

IV. VACANCY POSITION

Category	No. of Posts sanctioned	No. in position	Not in position since (mention date for each vacancy)
MO (including specialist) Dental Surgeon Staff Nurses / Nurses mid-wife Pharmacist / Compounder Lab Tech. / Lab assist. Radiographer Computer Driver Paramedical Supervisor (Malaria Inspector) (BEE) (PHN / LHV) (HA) Multi-purpose worker Male			

INVENTORY OF DRUGS, VACCINES, LAB CONSUMMABLES AND EQUIPMENT

Sl. No.	Item	Unit	Stock in Hand	Consumption	Balance Stock	Stock sufficient for months
1.	ORS Packets					
2.	Tubal Rings					
3.	Laparoscope					
4.	Nirodh Packets					
5.	Oral Pill Packets					
6.	IUDs					
7.	Iron Solutions					
8.	Vitamin A Solution					
9.	IFA Large Tablets					
10.	IFA Small Tablets					
11.	DPT Vaccine					
12.	Polio Vaccine					
13.	TT Vaccine					
14.	BCG Vaccine					
15.	DT Vaccine					
16.	Measles Vaccine					
17.	RTI / STI Drugs					
18.	MTP Suction Apparatus					

Number of inspections made by MO, PHC during the month :

1. LHV_____
2. ANM_____
3. Male Health Worker_____

Number of Villages visited :_____

Note on Progress made_____

_____

Signature MO (PHC)

To be submitted by 20th of following month to District Family Welfare Officer for Data-Entry in NIC-District Computer)

FORM 8

MONTHLY REPORT FOR FRU / CHC / SUBDIVISIONAL HOSPITAL / PPC DISTRICT HOSPITAL (REPORT OF MOIC)

1. State :_____
2. District :_____
3. PHC :_____
4. Population of PHC :_____
5. Reporting for the month of :_____
6. Eligible couples (as on 1st April of the year) :_____

II. Services

Sl. No.	Services	Performance in corresponding month last year		Performance in the reporting month		Cumulative performance till corresponding month of last year		Cumulative performance till current month		Planned performance in current year
1.	**Ante Natal Care**									
1.1	Ante Natal cases Registered									
	a) Total									
	b) Less than 12 weeks									
1.2	No. of pregnant women who had 3 check-ups									
1.3	Total No. of high risk pregnant women attended									
1.4	No. of TT doses									
	a) TT1									
	b) TT2									
	c) Booster									
1.5	No. of pregnant women under treatment for anaemia									
1.6	No. of pregnant women given prophylaxis for anaemia									
2.	**Natal Care**									
2.1	Total No. of deliveries conducted									
	a) Normal									
	b) Operative									
	i) Forceps									
	ii) LSCS									

3.	**Pregnancy Outcome**	M	F	M	F	M	F	M	F	
3.1	No. of births									
	a) Live births									
	b) Still births									
3.2	Order of birth in 3.1 (a)									
	a) 1st									
	b) 2nd									
	c) 3+									
3.3	New born status at birth									
	a) Less than 2.5 Kg.									
	b) 2.5 Kg. or more									
3.4	No. of high risk new borns attended									
4.	**Post Natal Care**									
4.1	No. of women given 3 post natal check-ups									
4.2	No. of Complications attended									
5.	**Maternal Deaths**									
5.1	During pregnancy									
5.2	During Delivery									
5.3	Within 6 weeks of delivery									
6.	**RTI / STI**	M	F	M	F	M	F	M	F	
6.1	Cases detected and treated									
7.	**Immunization**									
7.1	Infants 0 to 1 year									
	BCG									
	DPT 1									
	DPT 2									
	DPT 3									
	OPV 0									
	OPV 1									
	OPV 2									
	OPV 3									
	MEASLES									
7.2	Children more than 18 months									
	DPT Booster									
	OPV Booster									

	Full Immunization									
7.3	Children more than 5 years DT									
7.4	Children more than 10 years TT									
7.5	Children more than 16 years TT									
8.	**Adverse reactions reported after Immunization**									
	Vitamin A administration (9 months to 3 years)									
	Dose 1									
	Dose 2									
	Dose 3 - 5									
9.	Childhood Diseases									
9.1	**Vaccine preventable diseases**									
	a) Diptheria									
	Cases									
	Deaths									
	b) Poliomyelitis									
	Cases									
	Deaths									
	c) Neo Natal Tetanus									
	Cases									
	Deaths									
	d) Tetanus other than Neo Natal									
	Cases									
	Deaths									
	e) Whooping cough									
	Cases									
	Deaths									
	f) Measles									
	Cases									
	Deaths									
9.2	ARI under 5 years (Pneumonia)									
	a) Cases									
	b) Treated with Co-trimoxozole									
	c) Deaths									

9.3	Acute Diarrhoeal diseases under 5 years a) Cases b) Treated with ORS c) Deaths										
10.	**Child Deaths** a) Within 1 week b) 1 week to 1 month c) 1 month to 1 year d) 1 year to 5 years										
11.	**Contraceptive Services**										
11.1	Male Sterilisation a) Conventional b) Non scalpel										
11.2	Female Sterilisation a) Abdominal b) Laparoscopic										
11.3	Total IUD insertions a) Cases followed up b) Complications c) Discontinued										
12.	**Abortions** a) Spontaneous b) No. of MTPs done c) Deaths										

INVENTORY OF DRUGS, VACCINES, LAB CONSUMMABLES AND EQUIPMENT :

Sl. No.	Item	Unit	Stock in hand	Consumption	Balance Stock	Stock sufficient for months
	CONSUMMABLES					
1.	Tubal Rings					
2.	IUDs					
3.	Condoms					
4.	Oral Pills					
5.	RTI / STI drugs					
	EQUIPMENTS	**AVAILABLE**		**FUNCTIONING**		
6.	MTP Suction Apparatus					
7.	ILR					
8.	Deep Freezer					
9.	Cold Box					
10.	Refrigerator					
11.	X-ray machine					
12.	Laproscope					
13.	Kit E-Laparotomy set					
14.	Kit F-mini Laparotomy set					
15.	Kit G-IUD insertion set					
16.	Kit H-Vasectomy set					
17.	Kit I-Normal delivery set					
18.	Kit J-Vacuum extraction set					
19.	Kit K-Embryotomy set					
20.	Kit L-Uterine evacuation set					
21.	Kit M-Equipment for anaesthesia					
22.	Kit N-Neo Natal resuscitation set					
23.	Kit O-Equipment and Reagents for bllok tests					
24.	Kit P-Donor blood transfustion set					

IV. STAFF POSITION

Category	No. of Posts sanctioned	Available	Not in position since (Mention date of each vacancy)
MO			
Specialist			
a) Anaesthetist			
b) Gynaecologist			
c) Paediatrician			
d) Pathologist			
Dental Surgeon			
Staff Nurses / Nurse mid-wife			
Pharmacist / Compounder			
Lab Tech. / Lab assist.			
Radiographer			
Computer			
Driver			
Paramedical Supervisors			
(Malaria Inspector)			
(BEE)			
(PHN / LHV)			
(HA)			
Multi-purpose worker			
Male			
Female			

Date of Inspection made in report in month by DMO : _____

Number of inspections made of PHC

Sub-Centres : _____

Number of villages visited : _____

Note on Progress made _____

_____

_____

Signature of MOIC

(To be submitted by 25th of following month to State Family Welfare Department and Department of Family Welfare, MOHFW, GOI, New Delhi through NICNET.)

FORM 9

CONSOLIDATED MONTHLY REPORT FROM DISTRICT TO STATE / CENTRE

General

1. State _____
2. District _____
3. Population of District _____
4. Reporting for the month of _____
5. Eligible Couples (as on1st April of the year) _____

Sl. No.	Service		
I	**ANC Registered**	- Cumulative till this month last year	
II	**Ante Natal Check-up Pregnancies**	- Cumulative till this month this year who have received 3 check-ups How many received - TT2 - Booster - IFA High risk Pregnancies - PHC - CHC - FRU - District Hospital - Urban Dispensary - PPC Complication Referral	
III	**Deliveries**	Total No. delivered - By Trained attendant ANM / LHV - Institutional Deliveries at Sub-centre PHC FRU District Urban Dispensary PPC - Complications - Referred	
IV	**Maternal Deaths**	During Pregnancy During Delivery Within six weeks of Delivery	
V	**Pregnancy Outcome** - - -	- No. of live births No. of still births Order of birth 1st 2nd 3rd and 3+ Weight of new born <2.5 Kg. > 2.5 Kg.	

(Form 9 contd.)

VI	**Neo-Natal Care**	Sick new born cases - Treated - Referred			
VII	**Post Natal**	Who have received 3 check-ups			
VIII	**RTI / STI**	No. of clinics in District No. of male cases treated No. of female cases treated Referred to - PHC - FRU - District			
IX	**MTP**	No. of Govt. Hospitals with MTP facilities No. of MTP cases done			
X	**Immunization**	Infants 0 to 1 year - BCG - DPT 1 - DPT 2 - DPT 3 - OPV 0 - OPV 1 - OPV 2 - OPV 3 - Measles Children more than 18 months - DPT Booster - OPV Booster - Fully immunized Children more than 5 years - DT Children more than 10 years - TT Children more than 16 years - TT Adverse reactions reported after immunization	M	F	Total
XI	**Vitamin A**	Dose 1 Dose 2 Dose 3 - 5			
XII	**Childhood Diseases**	Vaccine preventable diseases Neonatal Tetanus Cases Deaths Diptheria Cases Deaths Poliomyelitis (Acute Flaccid Paralysis) Cases Deaths Tetanus (Others) Cases Deaths			

		Whooping Cough Cases Deaths Measles Cases Deaths Pneumonia under 5 year of age Cases Cases treated with cotrimoxozole Cases referred Deaths Acute Diarrhoeal diseases Cases Cases treated with ORS Cases referred Deaths
XIII	**Child Deaths**	Within one week of birth Within one week to one month of birth Within one month to one year of birth Within one year to five years of birth
XIV	**Contraception**	Male Sterilisation Female Sterilisation IUDs insertions Oral Pills Condom users No. of hospitals which did at least 1 1) Conventional Vasectomy 2) Non scalpel Vasectomy 3) Abdominal Tubectomy 4) Laproscopic Tubectomy
XV	**Abortions**	
XVI	**Stock position**	Vaccine DPT In Stock Out Stock OPV In Stock Out Stock TT In Stock Out Stock DT In Stock Out Stock BCG In Stock Out Stock Measles In Stock Out Stock

		Contraceptive Condoms In Stock Out Stock Oral Pills In Stock Out Stock IUDs In Stock Out Stock Tubal Rings In Stock Out Stock **Iron** IFA large In Stock Out Stock **Vitamin A Solution** In Stock Out Stock **ORS Packets** In Stock Out Stock	
XVII	**Cold Chain Equipment**	**ILR - 300** Total supplied Total not working **DFz - 300** Total supplied Total not working **ILR - 140** Total supplied Total not working **DFz - 140** Total supplied Total not working	
XVIII	**Staff Position**	**Speciialist in CHC / FRU** No. Sanctioned No. Vacant No. who have received RCH Training **Doctors in PHC** Sanctioned Vacant ANMs in Sub-Centre Sanctioned Vacant **Male Health Worker** Sanctioned Vacant **Lady Health Visitor** Sanctioned Vacant	

Signature of
Distt. Family Welfare Officer

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